

303 N. Church Street
Murfreesboro, TN 37130

RUTHERFORD COUNTY GOVERNMENT
"ON-THE-JOB INJURY" CLAIM REPORT

Phone (615) 898-7715
Fax (615) 867-4602

Claim ☐ Report only ☐

Claim # _____
(Office Use Only)

Date of Injury: _____
Date of Report: _____

Time of Injury: _____
AM ☐ PM ☐

As is allowed by T.C.A. 50-6-106, Rutherford County (RC) has opted to withdraw from the Tennessee Workers' Compensation Act, and instead has chosen to implement an On-The-Job Injury Program administered by the Rutherford County Risk Management Department.

Employee Name	_____			Gender	<input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth	_____
Address	_____					Date of Hire	_____
City	_____	State	_____	Zip	_____	Social Security No	_____
Home Phone	_____	Work Phone	_____			Cell Phone	_____
Work Location	_____						
Injury Location	_____						
Time employee began work on the date of injury:	_____					AM <input type="checkbox"/> PM <input type="checkbox"/>	

Affected area (please "X" all appropriate areas). (If multiple areas are affected, please "X" all areas that apply).

<input type="checkbox"/> Ankle	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Elbow	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Groin	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Mouth	<input type="checkbox"/> Stomach	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Arm	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Eye	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Hand	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Back	<input type="checkbox"/> up	<input type="checkbox"/> lwr	<input type="checkbox"/> Face	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Head	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Nose	<input type="checkbox"/> Thigh	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Buttock	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Finger	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Hip	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Ribs	<input type="checkbox"/> Toe	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Cheek	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Foot	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Jaw	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Teeth	<input type="checkbox"/> Wrist	<input type="checkbox"/> rt	<input type="checkbox"/> lft
<input type="checkbox"/> Chest	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Forehead	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Knee	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Throat			
<input type="checkbox"/> Ear	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Genital			<input type="checkbox"/> Leg	<input type="checkbox"/> rt	<input type="checkbox"/> lft	<input type="checkbox"/> Skin			

Injury Type (please X)

<input type="checkbox"/> Burn	<input type="checkbox"/> Chemical	<input type="checkbox"/> Cut	<input type="checkbox"/> Lifting	<input type="checkbox"/> Human Bite	<input type="checkbox"/> Insect Bite	<input type="checkbox"/> Animal Bite	<input type="checkbox"/> Machine Injury	<input type="checkbox"/> Slip/Fall	<input type="checkbox"/> Student Assault	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Other _____
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Describe - please enter details of events causing injury. (Please be sure to enter what employee was doing just before the injury occurred.)

I hereby understand that all OJI Claims are investigated by the Rutherford County (RC) Risk Management Department. Completion of an OJI Claim Report and/or an Employee Injury Statement or attempting to file a claim does not guarantee acceptance of the individual claim. Therefore, after a full Investigation of my claim, my claim may be non-compensable although I may have already seen an OJI Physician with OJI office approval. If that occurs, bills prior to the investigation will be paid in full by the Risk Management Department and I understand that I will be responsible for any further treatment or medication. I also understand that any unauthorized treatment or failure to seek medical treatment within 7 days of the injury will terminate my OJI benefits. I also hereby authorize the release of my protected health information from any and all health care providers, their employees, and agents and direct them to release or disclose to RC Risk Management Department (address above) my complete medical record regardless of stated areas of injury. I waive my right to confidentiality of these records for the purpose of an on-the-job injury. These records may be used by the RC Risk Management Department in making a determination as to my eligibility for benefits under the On-The-Job Injury Program. Unless otherwise stated, this authorization expires 365 days from the date of execution. Making a false or fraudulent claim is immediate grounds for termination from RC Government. I also understand the Safety Coordinator or their representative has the right to attend all visits with me and my physician. A physician must be selected from the list below.

<input type="checkbox"/> Concentra 1203 A Memorial Blvd Murfreesboro, TN 37129 Phone (615) 895-4855	<input type="checkbox"/> Physicians Medical 1525 South Church St. Murfreesboro, TN 37130 Phone (615) 217-7236	<input type="checkbox"/> U.S. Health Works 1332 Hazelwood Drive Smyrna, TN 37167 Phone (615) 267-2006	<input type="checkbox"/> Middle TN Occupational & Environmental 1227 Heil Quaker Blvd. LaVergne, TN 37086 Phone (615) 641-3080
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INFORMATION: Injury must be reported to the supervisor / Department Head immediately or within the current working shift. Care / treatment may be sought after the injury has been reported. When claim form is completed employee should fax report to the Risk Management Department @ (615) 867-4602.

Name of Supervisor Notified: _____ Date: _____ Time: _____

Has Employee scheduled a doctor's appointment.

Schedule Drs. Appointment: ☐ Yes ☐ No If so, Appt. Date: _____ Time: _____ AM ☐ PM ☐

Employee Signature: _____ Date: _____

OJI CLAIM REPORT